SECTION 61: ADULT DAY SERVICES

61.01 DEFINITIONS.

(A) **Adult Day Services** means an appropriately licensed program that receives funding assistance from Bureau of Elder and Adult Services for consumers who require assistance in paying for this service.

(B) **Activities of daily living (ADLs)** ADLs shall only include the following as defined in Section 61.02: bed mobility, transfer, locomotion, eating, toileting, bathing and dressing

(C) **Authorized Agent** means an organization authorized by the Department to perform reimbursable functions as specified in this section. The Licensed Adult Day Service provider is the Authorized Agent under this Section.

(D) **Authorized Service plan means** a plan which is authorized by the Adult Day Service provider, or the Department, which shall specify all services to be delivered to a recipient under this Section, including the number of hours for all covered services. The service plan shall be based upon the recipient's assessment outcome scores and the timeframes contained therein, recorded in the Department's medical eligibility determination (MED) form. The Adult Day Services provider has the authority to determine and authorize the service plan. All authorized covered services provided under this Section must be listed in the care plan summary on the MED form.

(E) **Care Plan Summary** is the section of the MED form that documents the Authorized Service Plan and services provided by other public or private program funding sources or support, service category, reason codes, duration, unit code, number of units per month, rate per unit, and total cost per month.

(F) **Covered Services are** those services for which payment can be made by the Department, under Section 61 of the Bureau of Elder and Adult Services policy manual.

(G) **Cueing** shall mean any spoken instruction or physical guidance, which serves as a signal to do something. Cueing is typically used when caring for individuals who are cognitively impaired.

(H) **Dependent Allowances.** Dependents and dependent allowances are defined and determined in agreement with the method used in the MaineCare program. The allowances are changed periodically and cited in the MaineCare Eligibility Manual, TANF Standard of Need Chart. Dependents are defined as individuals who may be claimed for tax purposes under the Internal Revenue Code and may include a minor or dependent child, dependent parents, or dependent siblings of the consumer or consumer's spouse. A spouse may not be included.

(I) **Disability-related expenses**: Disability-related expenses are out-of-pocket costs incurred by the consumers for their disability, which are not reimbursed by any third-party sources. They include:

(1) Home access modifications: ramps, tub/shower modifications and accessories, power door openers, show seat/chair, grab bars, door widening, environmental controls;

(2) Communication devices: adaptations to computers, speaker telephone, TTY, Personal Emergency Response Systems;
(3) Wheelchair (manual or power) accessories: lab tray, seats and back supports;
(4) Vehicle adaptations: adapted carrier and loading devices, one communication device for emergencies (limited to purchase and installation), adapted equipment for driving;
(5) Hearing Aids, glasses, adapted visual aids;
(6) Assistive animals (purchase only);
(7) Physician ordered medical services and supplies;
(8) Physician ordered prescription and over the counter drugs; and
(9) Medical insurance premiums, co-pays and deductibles.

(J) Household members: means the consumer and spouse

(K) Household members' income includes:

(1) Wages from work, including payroll deductions, excluding state and Federal taxes and employer mandated or court ordered withholdings;

(2) Benefits from Social Security, Supplemental Security Insurance, pensions, insurance, independent retirement plans, annuities, and Aid and Attendance;

(3) Adjusted gross income from property and/or business, based on the consumer's most recent Federal income tax; and

(4) Interest and dividends.

Not included are benefits from: the Home Energy Assistance Program, Food Stamps, General Assistance, Property Tax and Rent Refund, emergency assistance programs, or their successors.

(L) Limited Assistance means the individual was highly involved in the activity over the past seven days, or 24 to 48 hours if in a hospital setting, but received and required

- guided maneuvering of limbs or other non-weight bearing physical assistance three or more times or
- guided maneuvering of limbs or other non-weight bearing physical assistance three or more times plus weight-bearing support provided only one or two times

(M) Liquid asset is something of value available to the consumer that can be converted to cash in three months or less and includes:

(1) Bank accounts;
(2) Certificates of deposit;
(3) Money market and mutual funds;
(4) Life insurance policies;
(5) Stocks and bonds;

(6) Lump sum payments and inheritances; and
(7) Funds from a home equity conversion mortgage that are in the consumer's possession whether they are cash or have been converted to another form.

Funds which are available to the consumer but carry a penalty for early withdrawal will be counted minus the penalty. Exempt from this category are mortuary trusts and lump sum payments received from insurance settlements or annuities or other such assets named specifically to provide income as a replacement for earned income. The income from these payments will be counted as income.

(N) Medical Eligibility Determination (MED) Form shall mean the form approved by the Department for medical eligibility determinations and service authorization for the service plan based upon the assessment outcome scores. The definitions, scoring mechanisms and time frames relating to this form as defined in Section 61 provide the basis for authorized services and the service plan by the Adult Day Services provider. The care plan summary contained in the MED form documents the authorized service plan to be implemented by the Adult Day Services provider in the service plan. The service plan summary also identifies other services the recipient is receiving, in addition to the authorized services provided under this Section.

(O) One-person Physical Assist requires one person over last seven (7) days or 24-48 hours if in a hospital setting, to provide either weight-bearing or non-weight bearing assistance for an individual who cannot perform the activity independently. This does not include cueing.

61.02 ELIGIBILITY

(A) General and Specific Requirements. To be eligible for adult day services reimbursed directly by Bureau of Elder and Adult Services with state funds, a consumer must:

(1) Be at least 18;
(2) Live in Maine;
(3) Lack sufficient personal and/or financial resources for Adult Day Services;
(4) For an individual have assets of no more than $50,000 or for couples have assets no more than $75,000.
(5) Be ineligible for the MaineCare Private Duty Nursing/Personal Care Services, Maine Care Home and Community-Based Benefits MaineCare Adult Day Health and MaineCare Consumer Directed Attendant Services programs.
(6) Not be participating in Section 63: In Home and Community Based Support Services, Section 68: Respite Care for People with Alzheimer's Disease or Related Disorders or the Consumer-Directed Home Based Care program enacted by 26 MRSA Section 1412-G .

(7) If the assessment for continued eligibility indicates medical eligibility for a MaineCare program and potential financial eligibility for MaineCare, consumers will be given written notice, that the consumer has up to thirty (30) days to file a MaineCare application. If Adult Day services are currently being received, services shall be discontinued if a Bureau of Family Independence notice is not received within thirty (30) days of the assessment date indicating that a financial application has been filed. Services shall also be discontinued if, after filing the application within thirty (30) days the application requirements have not been completed in the time required by MaineCare policy.

(8) Not be residing in a hospital, nursing facility, ~~or~~ a licensed residential care facility or assisted living program.

(9) Consumer or legal representative agrees to pay the monthly calculated consumer payment.

(B) Medical and Functional Eligibility Requirements

Applicants for services under this section must meet the eligibility requirements as set forth in Section 61.02-B and documented on the Medical Eligibility Determination (MED) form. Medical eligibility will be determined using the MED form as defined in Section 61.01.

(1) Eligibility: A person meets the medical eligibility requirements for Adult Day Services if he or she requires the combination of criteria of Activities of Daily Living,

(a) Requires cueing 7 days per week for eating, toilet use, bathing, and dressing as defined in Section 61.01; or

(b) Requires limited assistance plus a one person physical assist with at least one (1) ADLs from the following: bed mobility, transfer, locomotion, eating, toilet use, dressing, and bathing.

(2) Activities of Daily Living:

(a) Bed Mobility: How person moves to and from lying position, turns side to side, and positions body while in bed;

(b) Transfer: How person moves between surfaces to/from: bed, wheelchair, standing position (excluding to/from bath/toilet);

(c) Locomotion: How person moves between locations, in room and other areas. If in wheelchair, self-sufficiency once in chair;

(d) Eating: How person eats and drinks (regardless of skill);

(e) Toilet Use: How person uses the toilet room (or commode, bedpan, urinal): transfers on/off toilet, cleanses, changes pad, manages ostomy or catheter, adjusts clothes;

(f) Bathing: How person takes full-body bath/shower, sponge bath and transfers in/out of tub/shower (exclude washing of back and hair); and

(g) Dressing: How person puts on, fastens, and takes off all items of street clothing, including donning/removing prosthesis.

61.03 Duration of Services

(A) Each Adult Day Services recipient may receive as many covered services as are required up to a maximum of thirty (30) hours per week. Coverage of services under this Section requires prior authorization for program funds from the Department based on the availability of program funds. Beginning and end dates of an individual's eligibility determination period correspond to the beginning and end dates for coverage of the Adult Day Services plan authorized.

(B) Services under this Section may be reduced, denied or terminated by the Department, or the Authorized Adult Day Services provider, as appropriate, for the following reasons:

(1) The consumer does not meet eligibility requirements.
(2) The consumer declines services.
(3) The consumer is eligible to receive long-term care services under MaineCare including any MaineCare Special Benefits.
(4) The consumer is eligible to receive services and funds are available for services under In Home and Community Support Services (Section 63) or the Consumer-Directed Home Based Care Program enacted by 26 MRSA Section 1412-G and there is a waiting list for services under Section 61.
(5) Services have been suspended for more than thirty (30) days.
(6) The consumer has failed to make his/her calculated monthly co-payment.
(7) There are insufficient funds to continue to pay for services for all current consumers, which results in a change affecting some or all consumers.

(C) Suspension. Services may be suspended for up to thirty (30) days while the consumer is hospitalized or using institutional care. If such circumstances extend beyond thirty (30) days, the recipient may be reassessed to determine eligibility if the provider determines there has been a significant change.

Notice of intent to reduce, deny, or terminate services under this section will be done in accordance with Section 40.01 of this policy manual.

61.04 Covered Services

Covered services are available for individuals meeting the eligibility requirements set forth in Section 61.02. All covered services require prior authorization by the Department, consistent with these rules, and are subject to the limits in Section 61.03. The Authorized Service Plan shall be based upon the recipient's assessment outcome scores recorded on the Department's Medical Eligibility Determination (MED) form, its definitions, and the timeframes therein and the absence of a caregiver or need of caregiver respite.

Services provided must be required for meeting the identified needs of the individual, based upon the outcome scores on the MED form, and as authorized in the service plan. Coverage will be denied if the services provided are not consistent with the consumer's authorized service plan. The Department may also recoup payment from the Adult Day Care provider for inappropriate services provision, as determined through post payment review. The Authorized Adult Day Services provider has the authority to determine the service plan, which shall specify all services to be provided, including the number of hours the recipient will attend for adult care.

Covered services are:

(1) Assistance with activities of daily living while attending the day services program
(2) Provision of snacks and a meal while in attendance at adult day service program
(3) Provision of activities, socialization and stimulation
(4) Transportation services necessary to perform activities and socialization services described in a recipients' plan of care, such as medical appointments. Reimbursement shall only be made for mileage in excess of ten (10) miles per single trip on a one way trip.
(5) Transportation services necessary to transport a consumer to the program and return home, provided this is a service of last resort. Mileage reimbursement rate shall not exceed an amount established by the Department.
(6) Any individual providing transportation must hold valid State of Maine driver's license for the type of vehicle being operated. All providers of transportation services shall maintain adequate liability insurance coverage for the type of vehicle being operated

61.05 Non Covered Services

The Following services are not reimbursable under this Section:

(A) Services for which the cost exceeds the limits described in Section 61.03;
(B) Adult Day Services for residents of licensed residential care or assisted living program;
(C) Services provided by a personal care assistant who has a notation on the CNA registry of

(1) Any criminal convictions, except for Class D and E convictions over ten (10) years old that did not involve, as a victim of the act, a patient, client, or resident of a health care entity; or
(2) Any specified documented findings by the State Survey Agency of abuse, neglect or misappropriation of property of a resident, client or patient.

61.06 POLICIES and PROCEDURES

(A) **Eligibility Determination** An eligibility assessment, using the Department's approved MED assessment form, shall be conducted by the Department, or the Authorized Adult Day Services provider. All Adult Day Services require

eligibility determination and prior authorization by the Department.

(1) The Authorized Adult Day Services provider will accept verbal or written referral information on each prospective new consumer, to determine appropriateness for an assessment. When funds are available, prospective consumers will receive a face to face medical eligibility determination assessment. All requests for assessments shall be documented indicating the date and time the assessment was requested and all required information provided to complete the request.

(2) The Authorized Adult Day Services provider shall inform the consumer of available community resources and authorize a service plan that reflects the identified needs documented by scores and timeframes on the MED form, giving consideration to the consumer's informal supports, and services provided by other public or private funding sources.

(3) The Adult Day Services provider shall authorize a service plan based upon the scores and findings recorded in the MED assessment. The covered services to be provided shall not exceed the weekly maximum number of hours established by Bureau of Elder and Adult Services. The maximum eligibility period for the consumer, shall not exceed twelve (12) months.

(4) The Adult Day Services provider will provide a copy of the authorized service plan, in a format understandable by the average reader, a copy of the eligibility notice, release of information to the consumer at the completion of the assessment. The Adult Day Services provider will inform the consumer of the calculated co-payment based on the cost of services authorized.

(5) The Adult Day Services provider is required to accept as payment in full the allowances established by BEAS for covered services under this section.

(B) Waiting List

(1) When funds are not available to serve new consumers who have been assessed and determined eligible for services under this section, or to increase services for current consumers, a waiting list will be established by the Adult Day Services provider. As funds become available consumers will be taken off the list and served on a first come, first served basis.

(2) For consumers found ineligible for Adult Day Services under this section, the Adult Day Services provider will inform each consumer of alternative services or resources, and offer to refer the person to those other services.

(3) The Department will maintain one statewide waiting list.

(4) If there is a waiting list the first come first serve basis for selection may be waived by the Department if in it's judgment it is necessary to respond to the emergency needs or special circumstances of a caregiver.

(C) Suspension. Services may be suspended for up to thirty (30) days while the consumer is hospitalized or using institutional care. If such circumstances extend beyond thirty (30) days, the recipient may be reassessed to determine eligibility if

the provider determines there has been a significant change.

(D) Reassessment and Continued Services

(1) For all recipients under this section, in order for the reimbursement of services to continue uninterrupted beyond the approved classification period, a reassessment and prior authorization of services is required and must be conducted no later than the reassessment date. Payment ends for Adult Day Services with the reassessment date, also known as the end date.

(2) An individual's specific needs for Adult Day Services shall be reassessed at least annually.

61.07 Professional and Other Qualified Staff

(A) The Adult Day Services Provider shall:

(1) Be open to serve consumers at least two days a week;
(2) Determine eligibility of applicants using the Medical Eligibility Determination (MED) form;
(3) Contact Bureau of Elder and Adult Services to request prior authorization if the applicant is determined eligible;
(4) Submit invoices for payment to Bureau of Elder and Adult Services on a Bureau of Elder and Adult Services approved billing form;
(5) Not bill for more than thirty (30) hours of Adult day services per week for each consumer.
(6) Manage requests for waiver of consumer payments;
(7) Provide any consumer or designated representative of any consumer with an unresolved complaint about the Adult Day Services with information on how to contact the Long Term Care Ombudsman;
(8) Refer consumers who need additional services to the Assessing Services Agency for an assessment.

61.08 Consumer Records and Program Reports

(A) **Content of Consumer Records**. The Adult Day Services provider must establish and maintain a record for each consumer that includes at least:

(1) The consumer's name, address, mailing address if different, and telephone number;
(2) The name, address, and telephone number of someone to contact in an emergency;
(3) Complete medical eligibility determination form and financial assessments and reassessments that include the date they were done and the signature of the person who did them;
(4) A service plan summary that promotes the consumer's independence matches needs identified by the scores and timeframes on the MED form and on the care plan summary on the MED form, with consideration of

other formal and informal services provided and which is reviewed no less frequently than semiannually. The service plan includes:

(a) Evidence of the consumer's participation;
(b) Who will provide what service, when and how often, the reason for the service and when it will begin and end;
(c) The signature of the person who determined eligibility and authorized a plan of care; and

(5) A dated release of information signed by the consumer that conforms with applicable law, is renewed annually and that:
(a) Is in language the consumer can understand;
(b) Names the agency or person authorized to disclose information
(c) Describes the information that may be disclosed;
(d) Names the person or agency to whom information may be disclosed;
(e) Describes the purpose for which information may be disclosed; and
(f) Shows the date the release will expire.

(6) Documentation that consumers eligible to apply for a waiver for consumer payments, were notified, that a waiver may be available;

(7) Written progress notes that summarize any contacts made with or about the consumer and:
(a) The date the contact was made;
(b) The name and affiliation of the person(s) contacted or discussed;
(c) Any changes needed and the reasons for the changes in the plan of care.

61.09 RESPONSIBILITIES OF THE BUREAU OF ELDER AND ADULT SERVICES

(A) The Bureau of Elder and Adult Services is responsible for:

(1) Setting the weekly individual service plan hour limit;
(2) Setting the maximum allowable, hourly reimbursement rate;
(3) Conducting monitoring visits;
(4) Providing written notification to the provider and if applicable, its governing body, of problems in the program and setting deadlines for corrections;
(5) Evaluating program data; and
(6) Reviewing randomly selected requests for waivers of consumer payment.

61.10 Consumer Payments. Consumers will pay 20% of the cost of Adult Day Services, except when they are granted a waiver. Consumers in Adult Day Services programs which use Title III funds are exempt from a required consumer payment but may be asked to make a donation comparable to the consumer payment.

(A) Waiver of Consumer Payment. Consumers will be informed that they may apply for waiver of all or part of the assessed payment when:

(1) Monthly income of household, as defined in Section 61.01(J) and 61.01(K), is no more than 200% of the federal poverty level; and

(2) Household assets are no more than $15,000.
(3) Calculation of the waiver of the consumer payment will be completed by the Adult day Services provider following the process described in Section 63.12.